

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

09270

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium, Colored Branch, Henryton, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
Maryland
 State Baltimore-17 County
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1709 Baker Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

HORACE ANTHONY

3. (b) Social Security Number

218-09-6674

4. Sex <u>Male</u>	5. Color or race <u>Col/</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>	
6. (b) Name of husband or wife			
7. Birth date of deceased (mo., day, yr.) <u>June 5, 1901</u>			
8. AGE:	Years <u>47</u>	Months <u>3</u>	Days <u>9</u>
	If less than one dayhrs.min.		
9. Birthplace <u>Scotland Neck, N. Carolina</u> (Town, county, and state)			
10. Usual occupation <u>Laborer</u>			
11. Industry or business <u>Edward Anthony</u>			
FATHER	12. Name <u>Scotland Neck, N. Carolina</u>		
	13. Birthplace		
MOTHER	14. Maiden name <u>Maggie Stevens</u>		
	15. Birthplace <u>Scotland Neck, N. Carolina</u>		

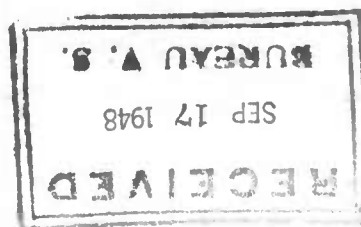
16. Informant Deceased
 Address
 17. Buried Date thereof Sept 18, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory W.B. Ambrose
 Location Baltimore, Maryland
 18. Funeral director Geo. G. Velasquez
 Address 1303 Chestnut St.
 19. Sept. 14 19 48 Albert R. Smith
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 19 48 at 4:30 P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 8 19 48 to Sept. 14 19 48
 and that I last saw him alive on September 14 19 48
 Immediate cause of death Pulmonary Tuberculosis
 DURATION November 1947
 Due to
 Due to
 Other conditions
 (Include pregnancy within 8 months of death)
 Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Neuben Hoffman, M.D.
 M. D. or other
 Address Henryton, Maryland Date signed 9/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09271

Reg. Dist. No. 74

1. PLACE OF DEATH

County CarrollCity or town Spencerville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 monthsHospital, institution, or street address where death occurred: Springfield State HospitalHow long in hospital or institution? 9 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County ...City or town Batavia
(If outside city or town limits, write RURAL and give nearest town)Street No. 3439 Mayfield Ave
(If rural, give LOCATION)2.(a) If veteran, name war ...

3. (a) FULL NAME

Alice Sophia Arthur

3. (b) Social Security Number

4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife John Arthur6. (c) If alive, give age 5 years7. Birth data of deceased (mo., day, yr.) Nov 26 - 1862

8. AGE:

Years 85Months 9Days 9

If less than one day

hrs. ...min. ...9. Birthplace Hagerston Ind.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business ...

MOTHER

FATHER

12. Name Lewis Decker13. Birthplace Germany14. Maiden name Sophia15. Birthplace Germany16. Informant Dr. Charlotte WickAddress 3443 Mayfield Ave Batavia17. Burial ...Date thereof Sept. 9, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory Safe Hill CemeteryLocation Hagerston, Maryland18. Funeral director Dr. W. K. ReedAddress Hagerston Maryland19. Sept 7 19 48

(Date rec'd by registrar)

Registrar C. H. ...

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6th 19 48 at 8-10⁰⁰ M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 5th 19 47 to Sept 6th 19 48and that I last saw her alive on Sept 6th 19 48

Immediate cause of death

Cerebral HemorrhageDue to ...Sub Arterio SclerosisDue to ...HypertensionOther conditions ...

(Include pregnancy within 8 months of death)

Major findings of operations ...Date of op. ...Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...Where did injury occur? ... (City or town) ... (County) ... (State)Injured at home, farm, industry, public place (where?) ...Means of injury ...Injured at work? ...23. SIGNATURE W. K. ReedM. D. or other ...Address Spencerville Ind. Date signed 10/1/48

RECEIVED

SEP 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09272

74

1. PLACE OF DEATH:

County Carroll
 City or town Henrington, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henrington, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County
 City or town Baltimore -2-
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 131 Preston Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war.

3. (a) FULL NAME

CALDWELL BADA

3. (b) Social Security Number

223-18-9986

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Separated
 6. (b) Name of husband or wife May Bady
 7. Birth date of deceased (mo., day, yr.) December 2, 1902
 6. (c) If alive, give age 51 years
 8. AGE: Years 45 Months 9 Days 24 If less than one day
 hrs. min.

9. Birthplace Staunton, Virginia
 (Town, county, and state)
 10. Usual occupation Handyman
 11. Industry or business
 12. Name William Bady
 13. Birthplace Virginia
 14. Maiden name Sarah Frances Miller
 15. Birthplace Virginia

16. Informant Deceased
 Address
 17. Buried Date thereof 9/30/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt Auburn
 Location Baltimore City
 18. Funeral director Geo. D. Nelson
 Address 1303 Preston St.
 19. Sept. 26 19 48 Albert R. Swankham
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 19 48 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 2 19 48 to September 26 19 48
 and that I last saw him alive on September 26 19 48

Immediate cause of death
Pulmonary Tuberculosis

DURATION
March
1948

Due to.

Due to.

Other conditions

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Reuben D. Brown M.D.
 M. D. or other
 Address Henrington, Maryland Date signed 9/26/48

STANDARD INFORMATION STATE

RECEIVED

RECEIVED

RECEIVED

RECEIVED

SEP 30 1948

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
birth date shown on:

RURAL No. G 117 SEP 21 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore-17-
(If outside city or town limits, write RURAL and give nearest town)

915 W. Fayette Street

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

EVELYN BARNES

3. (b) Social Security Number

4. Sex FE Male 5. Color or race Col 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Freddie Barnes

7. Birth date of deceased (mo., day, yr.) May 21, 1906 1916 8. (c) If alive, give age years

8. AGE: Years 32 Months 4 Day 24 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Elizabeth Parker

15. Birthplace Virginia

16. Informant Deceased

17. Address

18. Informant

19. Address

20. Address

21. Address

22. Address

23. Address

24. Address

25. Address

26. Address

27. Address

28. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 19 48 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16 19 48 to September 14 19 48

and that I last saw him/her alive on September 14 19 48

Immediate cause of death Pulmonary Tuberculosis

DURATION November 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D.

Address Henryton, Maryland Date signed 9/14/48

19. Sept. 14 19 48 Deputy Registrar

(Date rec'd by registrar)

RECEIVED
SEP 17 1948
BUREAU A. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County... Carroll
 City or town... Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years, 11 months, 3 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 4 years, 11 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County... ---
 City or town... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 3211 Belair Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ---

3. (a) FULL NAME

BENDT, John BENDT

3. (b) Social Security Number

4. Sex MALE 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife... ---
 6.(c) If alive, give age... --- years
 7. Birth date of deceased (mo., day, yr.) November 18, 1882
 8. AGE: Years 65 Months 9 Days 27 If less than one day
hr.min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation... Merchant
 11. Industry or business... ---
 12. Name... unkn.
 13. Birthplace Germany
 14. Maiden name... Louise Bender
 15. Birthplace Germany

16. Informant Records of Springfield St. Hospital
 Address Sykesville, Maryland
 17. Burial Date thereof Sept. 17, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... ---
 Location... Baltimore, Md.
 18. Funeral director... H. H. Hitzke
 Address Hollins & Gilman Sts. Balto.
 19. Sept. 14, 1948 Harry Meier
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... September 14, 1948 at 7:20 a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 1, 1947, to September 19, 48
 and that I last saw him alive on September 19, 48

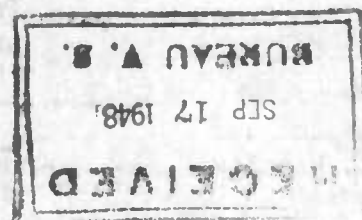
Immediate cause of death Bronchopneumonia
 DURATION 1 wk.

Due to... ---
 Due to... ---
 Other conditions Psychosis with cerebral arteriosclerosis 5 yrs.
 (Include pregnancy within 8 months of death)

Major findings of operations... --- Date of op. ---
 Autopsy results Bronchopneumonia
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... --- Date of... ---
 Where did injury occur? --- (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) ---
 Cause of injury --- Injured at work? ---

23. SIGNATURE Martin Gross, M.D. M. D. or other
 Address Sykesville, Maryland Date signed 8/14/48



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County CarrollCity or town Springfield
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 yrs 23 daHospital, institution, or street address where death occurred Springfield State HospitalHow long in hospital or institution? 7 mo 23 da

3. (a) FULL NAME

Anna Blanche Berlin

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 2 1906

6. (c) If alive, give age years

8. AGE:

Years

42

Months

7

Days

16

If less than one day

hrs.min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date

(Date rec'd by registrar)

19. H.S.

C. Harry Reed

19. H.S.

C. Harry Reed

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 18 1945 19 45 430^P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 26 1930 19 30 Sept 18 1945 19 45

and that I last saw him alive on

Sept 18 1945 19 45

Immediate cause of death

Right Pulmonary embolism

Due to

septic cervicitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

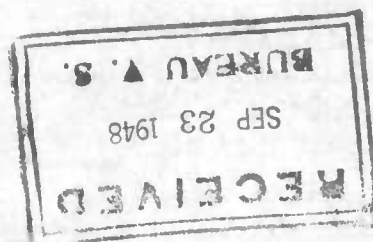
Injured at work?

23. SIGNATURE

Address

Date signed

Sept 18 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 81.

1. PLACE OF DEATH:

County CarrollCity or town Middleburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Middleburg
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Susie Ellen Birely

3. (b) Social Security Number

none

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Nov 3 - 1874

8. AGE:

Years

Months

Days

If less than one day

73929

hrs.

min.

9. Birthplace

Middleburg, Maryland
(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business _____

FATHER

12. Name

Francis J Birely

13. Birthplace

Maryland

MOTHER

14. Maiden name

Susan Angell

15. Birthplace

Maryland

16. Informant

Lowell M Birely

Address

Union Bridge, Md

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

Sept 4 - 1948
(month) (day) (year)

Cemetery or crematory

Mt Union

Location

Union Bridge, Md. R.D

18. Funeral director

O.D. Hartley & Son

Address

Union Bridge & New Windsor, Md

19.

Sept 2
(Date rec'd by registrar)

19

48Michigan

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 1, 1948

21. I CERTIFY that death occurred on the date above stated; that (attended deceased from

Sept 1 to Sept 1 1948
and that I last saw him alive on Sept 1 1948

Immediate cause of death

DURATION

Due to

Due to

Other conditions

153
462

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Musher M.D.

M. D. or other

Address

Union Bridge, Md
Sept 2

RECEIVED

APR 9 1949

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

FILM No. G 117 SEP 30 1948

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 hours, 45 minutes
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Br nch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County _____
City or town Baltimore, 17
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1525 Riggs Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME Ophelia Blackwell 3. (b) Social Security Number _____

4. Sex female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced UNK.
6. (b) Name of husband or wife _____
7. Birth date of deceased (mo., day, yr.) 1910 8. (c) If alive, give age _____ years
8. AGE: Years 38 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace UNK.
(Town, county, and state)
10. Usual occupation UNK.
11. Industry or business _____
12. Name UNK.
13. Birthplace _____
14. Maiden name UNK.
15. Birthplace _____

16. Informant UNK.
Address _____
17. Removal Date thereof UNK.
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory _____
Location Balt. city morgue
18. Funeral director Mr. Henry
Address 578 W. B. Wolfe St.
19. September 5, 1948 Alvin R. Hoffman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH September 5, 1948 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 5, 1948 to September 5, 1948 and that I last saw h er alive on September 5, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION Unknown

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Heuben Hoffman, M.D. M. D. or other _____
Address Henryton, Maryland Date signed 9-5-48

Deputy Local

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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se
8761

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09277

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carpoll
City or town Springfield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs 4 mo 1 da
Hospital, institution, or street address where death occurred Springfield State Hospital
How long in hospital or institution? 2 yrs 4 mo 1 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No 2307 Conestoga Glen Road
(If rural, give LOCATION)

3. (a) FULL NAME

Martha Blundon

3. (b) Social Security Number

✓

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife William E. Blundon

7. Birth date of deceased (mo., day, yr.) July 22 - 1870 6. (c) If alive, give age 78 years

8. AGE: Years 78 Months 1 Days 13 It less than one day hrs. min.

9. Birthplace New York
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Harvey Benjamin

12. Name Harvey Benjamin

13. Birthplace New York

14. Maiden name Amelia A. Boardman

15. Birthplace New York

16. Address 2307 Conestoga Glen Rd

17. removal Date thereof (month) (day) (year) Sept 6 48

Cemetery or crematory Silver Spring, Md.

Location Warner E. Pumphrey Inc.

18. Funeral director Warner E. Pumphrey Inc.

Address 8434 Ga. ave. S.E. Md.

19. Sept 6 19 48 C. Harry Egan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5th 1948 at 2:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3d 1946 to Sept 5th 1948 and that I last saw her alive on Sept 5th 1948

Immediate cause of death Arterial Hemorrhage DURATION 1 wk

Due to Arterial Sclerosis

Due to Hypertension

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Date of op. ✓

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of ✓

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ✓ Injured at work?

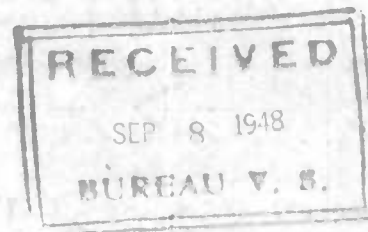
23. SIGNATURE J. J. Weston M.D.

Address Silver Spring Md Date signed 9-5-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09278

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year 9 months 26 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 55 Spar Road
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

MARION BOOTH

3. (b) Social Security Number

4. Sex Female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) November 23, 1923
 8. AGE: Years 24 Months 9 Days 28 If less than one day
 hrs. min.

9. Birthplace Annapolis, Maryland
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Rev. Herbert Booth
 13. Birthplace Maryland
 14. Maiden name Amanda Ayers
 15. Birthplace Maryland

16. Informant Mother- Mrs. Amanda Booth
 Address 55 Spar Road, Annapolis, Maryland

17. Burial Date thereof Sept 24 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Brewer Hill Cemetery
 Location Annapolis, Maryland

18. Funeral director William H. Lee II
 Address 1083 Washington St. Annapolis, Md.

19. Sept. 20 48
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 19 48 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 25 19 46, to Sept. 20 19 48

and that I last saw her alive on September 20 19 48

Immediate cause of death
Pulmonary Tuberculosis

DURATION

May
1946

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

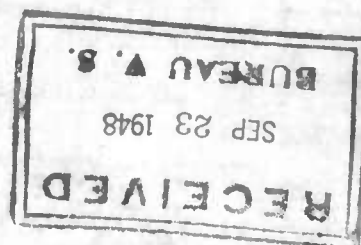
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben D. Hoffman, M.D.

M. D. or other

Henryton, Maryland Date signed 9/20/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County Carroll
 City or town Manchester Md Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Entire Life
 Hospital, institution, or street address where death occurred:
HARVARD PIKE
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Manchester Md Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. HARVARD PIKE
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alletta B. Brehm

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife William S. Brehm
 7. Birth date of deceased (mo., day, yr.) January 9 1888 6.(c) If alive, give age 60 years
 8. AGE: Year 60 Months 8 Days 12 If less than one day hrs. min.

9. Birthplace Westminster Md RD #4
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name John T. Albough

13. Birthplace Maryland

14. Maiden name Elizabeth Beale

15. Birthplace Maryland

16. Informant William S. Brehm

Address Manchester, Md

17. Burial Date thereof Sept. 24, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Leisters Cemetery

Location Westminster 4. Md.

18. Funeral director H. Bankard Hon

Address Westminster, Md.

19. Sept. 21 1948 Attest H. P. J. Devere
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1948 at 9:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1 1947 to Sept 21 1948

and that I last saw him alive on Sept 20 1948

Immediate cause of death Melanotic Carcinoma of Lung DURATION ?

Due to Cervical Carcinoma of Breast ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Cervical Carcinoma Lung

Date of op. 1-1-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph E. Beale Md M. D. or other

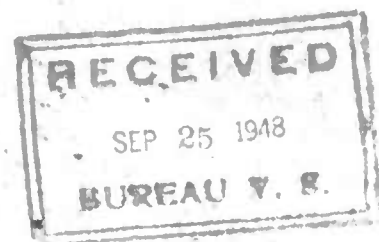
Address Hampstead Md Date signed 9/21/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County CarrollCity or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year 1 month 3 daysHospital, institution, or street address where death occurred:
Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch, Henryton, Md

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 291 N. Exeter Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Carmelita DAVIS

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Col.

6.(a) Single, married, widowed, or divorced

Single

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 1, 1933

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

15220

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Scholar

11. Industry or business

MOTHER FATHER

12. Name

William Davis

13. Birthplace

N. Carolina

14. Maiden name

Hilda Sorrell

15. Birthplace

Baltimore, Maryland

16. Informant

Deceased

Address

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Sept 25th 48
(month, (day) (year)

Cemetery or crematory

St. John's Cemetery

Location

Box 124

18. Funeral director

Oliver J. Wilson

Address

1000 Bae Brantley

19.

Sept. 2119 48

(Date rec'd by registrar)

Deputy Local

Registrar

23. SIGNATURE

Robert M. D.
M. D. or otherAddress Henryton, MarylandDate signed 9/21/48

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 19 48 at 4:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18 19 47, to September 21 19 48and that I last saw him/her alive on September 21 19 48

Immediate cause of death

Pulmonary Tuberculosis

DURATION

November 1946

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

M. D. or other

RECEIVED
SEP 23 1948
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09281

Reg. Dist. No. 74

1. PLACE OF DEATH:

County CarrollCity or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 months, 17 days

Hospital, institution, or street address where death occurred:

Springfield State HospitalHow long in hospital or institution? 9 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Lisbon
(If outside city or town limits, write RURAL and give nearest town)Street No. ---
(If rural, give LOCATION)2. (a) If veteran, name war ---

3. (a) FULL NAME

DeLashmutt, Charles Edward

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>male</u>	<u>white</u>	<u>married</u>

6. (b) Name of husband or wife Agnes Cavey DeLashmuttBorn 9/12/1889 6. (c) If alive, give age --- years7. Birth date of deceased (mo., day, yr.) May 15, 1883

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>4</u>	<u>5</u>	<u>---</u> hrs. <u>---</u> min.

9. Birthplace Howard County, Maryland
(Town, county, and State)10. Usual occupation Merchant and postmaster11. Industry or business ---12. Name Franklin Dill DeLashmutt13. Birthplace Frederick, Maryland14. Maiden name Martha Davis15. Birthplace Frederick, Maryland16. Informant Records of Springfield St. HospitalAddress Sykesville, Maryland17. Burial Oak Grove Date thereof 9-23-48
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Glenwood, Howard Co., Md.Location C. M. Waltz18. Funeral director Winfield, Md.Address ---19. Sept 22 1948 O. Harry Hees
(Date rec'd by registrar) Registrar

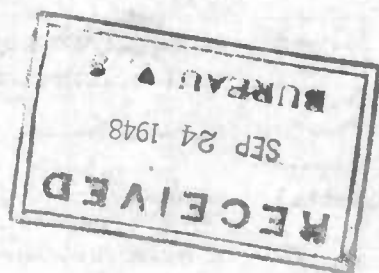
MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 19 48 at 3:15 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 19 48 to September 20 19 48 and that I last saw him alive on September 20 19 48Immediate cause of death Bronchopneumonia DURATION 5 daysDue to ---Due to ---Other conditions Psychosis with cerebral arteriosclerosis. Hemiplegia 10 yrs. 10 months
(Include pregnancy within 1 year of death)Major findings of operations ---Date of op. ---Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? --- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---23. SIGNATURE Martin Gross, M.D.
Martin Gross, M. D. M. D. or otherAddress Sykesville, Maryland Date signed 9/20/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

09282

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months 28 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore-1-
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 625 W. Biddle Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

COLUMBUS DICKENS

3. (b) Social Security Number

229-18-1428

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) October 3, 1920 8. (c) If alive, give age _____ years

8. AGE: Years 27 Months 11 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Petersburg, Virginia
 (Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business _____

12. Name Unknown
 13. Birthplace Unknown

14. Maiden name Lida Dickens
 15. Birthplace Unknown

16. Informant Deceased

Address _____
 17. Removal Date thereof Sept. 10, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Public City morgue18. Funeral director Mr. HenryAddress 578 W. Biddle St

September 7 48
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 19 48 at 1:20 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 10 19 48 to September 7 19 48
 and that I last saw him alive on September 7 19 48

Immediate cause of death _____
Pulmonary Tuberculosis
 DURATION March 1948

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, term, industry, pub'c place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Neelam M. D.

M. D. or other

Address Henryton, Maryland Date signed 9/7/48

RECEIVED
SEP 13 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09283

Reg. Diat. No.

74

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Flintstone
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

MARY ELLA ELLWOOD

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced S
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 2, 1891
 8. AGE: Years 57 Months 6 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace West Virginia
 (Town, county, and state)
 10. Usual occupation Housekeeper
 11. Industry or business _____
 12. Name Franklin Ellwood
 13. Birthplace Ireland
 14. Maiden name Nellie Catterton
 15. Birthplace Kentucky

16. Informant Record, Springfield State Hospital
 Address Sykesville, Maryland

17. Burial Date thereof 9/10/48
 (Burial, cremation, or removal. Which?) (Month) (day) (year)
 Cemetery or crematory Elmwood Cemetery
 Location Shepherdstown, West Va.
 18. Funeral director Merwin P. Strider
 Address Charles Town, West Va.
 19. Sept 8 19 48 Harry Keen
 (Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

(DST)

20. DATE OF DEATH September 7 19 48 at 7:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 24 19 48 to September 7 19 48
 and that I last saw her alive on September 7 19 48

Immediate cause of death Myocarditis with myocardial degeneration
 DURATION known since 8/24 1948

Due to _____
 Due to _____

Other conditions Psychosis with cerebral arteriosclerosis known since 8/24/48
 (Include pregnancy within 8 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, pub'c place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE M. Virginia Beyer M.D. M. D. or other _____
 Address Sykesville, Maryland Date signed 9/7/48

RECEIVED
SEP 11 1948
BUREAU A. B.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09284

Reg. Dist. No. 72

1. PLACE OF DEATH:

County... Carroll
 City or town... Myers District, Westminster R.D. 2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Carroll
 City or town... Myers District
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Westminster R.D. 2
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Orestus Wilson Feeser

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Isadora Kump Feeser
 6. (c) If alive, give age Dead years
 7. Birth date of deceased (mo., day, yr.) November 25 1867
 8. AGE: Years 80 Months 9 Days 27 It less than one day hrs. min.

9. Birthplace Carroll County, Md.
 (Town, county, and state)
 10. Usual occupation Farming
 11. Industry or business Farm
 12. Name Jacob Feeser
 13. Birthplace Carroll County, Md.
 14. Maiden name Elizabeth Myers
 15. Birthplace Carroll County, Md.

16. Informant Bertha Feeser
 Address Westminster, Md. R.D. 2
 17. Burial Date thereof 9/25/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Marys Union Cemetery
 Location Silver Run, Md.

18. Funeral director J. M. Little & Son
 Address Littlestown, Pa. Per R. A. Little

19. Sept 23rd 19 48 Calvin B. Bantz
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 19 48 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2 19 48 to September 22 19 48
 and that I last saw him alive on September 21 19 48

Immediate cause of death arteriosclerotic
cardio renal disease
myocardial degeneration
 Due to

DURATION
several
years

Due to
 Other conditions Arteriosclerotic
hypertrophy
 (Include pregnancy within 3 months of death)
several
years

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE W. Lewis Springer M. D. or other
 Address Westminster, Md. Date signed 9/22/48

BAG CONTENT

RECEIVED
SEP 29 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09285

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 10 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital, Sykesville, Md.
How long in hospital or institution? 4 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard Baltimore
City or town nr. Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No. Westchester & Rockwell Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME

LILLIAN FRASER

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife John Fraser--deceased

7. Birth date of deceased (mo., day, yr.) unknown Jan. 14, 1895 6.(c) If alive, give age year

8. AGE: Year 73 Months 8 Days 11 If less than one day hrs. min.

9. Birthplace Savage, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James Grady
13. Birthplace Maryland
14. Maiden name Mary Jane Leizear
15. Birthplace Maryland

16. Informant Hospital records

Address

17. Burial Date thereof 9-28-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Woodlawn Cemetery
Location Bald Md.

18. Funeral director Edmund Marshall
Address Catonville Md.

19. Sept 25 1948 Registrar C. Harry Wilson
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25th 1948 at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15th 1948 to Sept. 25th 1948
and that I last saw her alive on September 25th 1948

Immediate cause of death Pulmonary tuberculosis DURATION 7 yrs.

Generalized arteriosclerosis ?
Myocardial degeneration ?

Due to Senile Psychosis 8 mths.

(Include pregnancy within 3 months of death)

Major findings of operations Senile Psychosis Date of op. 8 mths.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

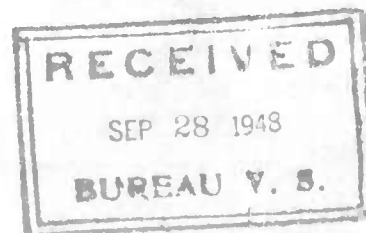
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Senile Psychosis Date of 8 mths.
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph H. Marshall, M.D.
Address S.S. Hospital, Sykesville, Md. Date signed 9-25-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



For change of county of Res. see letter from Dr. Shrop, also case (CD) is on
file as Baltimore Co. 10-22-48ams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09286

Reg. Dist. No. *80*

1. PLACE OF DEATH:

County *Carroll*City or town *New Windsor*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *Lifetime*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex *male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *widowed*6. (b) Name of husband or wife *Anna Mary Seatty*7. Birth date of deceased (mo., day, yr.) *Feb. 3 - 1882* 6. (c) If alive, give age *66* years8. AGE: Years *66* Months *7* Days *14* It less than one day *hrs. min.*9. Birthplace *Carroll County, Md*
(Town, county, and state)10. Usual occupation *Physician*

11. Industry or business

12. Name *Henry Seatty*13. Birthplace *Maryland*14. Maiden name *Virginia Biehl*15. Birthplace *Maryland*16. Informant *Mrs. Gertrude Lambert*Address *New Windsor, Md*17. *Burial* Date thereof *9/20/48*
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory *Winters Cemetery*Location *Union Bridge Road*18. Funeral director *H. H. Hartzler & Sons*Address *Union Bridge & New Windsor, Md.*19. *Sept 19 48* *Grandfather*
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Carroll*City or town *New Windsor*
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept. 17* 19 *48* at *10:00 A*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept 6* 19 *48* to *Sept 17* 19 *48*and that I last saw him alive on *Sept 17* 19 *48*Immediate cause of death *Cerebral Hemorrhage*

DURATION

Due to *Cardio-Vascular Disease*

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *James T. March* M. D. or otherAddress *Winters Cemetery* Date signed *9/17/48*

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 15 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel Co.
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 191 Clay Street
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war

3. (a) FULL NAME

Thelma Simms Gray

3. (b) Social Security Number

4. Sex female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Walter Gray
 7. Birth date of deceased (mo., day, yr.) August 30, 1919 8. (c) If alive, give age 27 years
 8. AGE: Years 29 Months 0 Day 6 If less than one day hr. min.

9. Birthplace Annapolis, Maryland
 (Town, county, and state)
 10. Usual occupation Domestic
 11. Industry or business
 12. Name Douglas Simms
 13. Birthplace Annapolis, Maryland
 14. Maiden name Cora Baden
 15. Birthplace Annapolis, Maryland
 16. Informant Deceased

Address Burial
 17. (Burial, cremation, or removal. Which?) Date thereof Sept. 8, 1948
 (month) (day) (year)
 Cemetery or crematory St. Mary's Cem.
Annapolis, Maryland
 Location
 18. Funeral director William Reese II
 Address 1882 Washington St. Annapolis, Md.
 19. September 5, 1948
 (Date rec'd by registrar) Deputy Registrar Deputy L. Cal

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5, 1948 at 5:45 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21, 1948 to September 5, 1948
 and that I last saw her alive on September 5, 1948

Immediate cause of death Pulmonary Tuberculosis
 DURATION Feb. 1948

Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Heaven Hoffman, M.D.
 M. D. or other
 Address Henryton, Maryland Date signed 9-5-48

UNITED STATES DEPARTMENT OF HEALTH

RECEIVED

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

RECEIVED

SEP 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09288

Reg. Dist. No. 81

1. PLACE OF DEATH:

County... Carroll
 City or town... Elmon Bridge Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For non-born infants give residence of mother)
 State... Maryland County... Carroll
 City or town... Elmon Bridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Rural
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William H. Grimm

3. (b) Social Security Number

218-07-2580

4. Sex

male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Sydney Alice Grimm

7. Birth date of deceased (mo., day, yr.)

Nov. 2 - 1868

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

791010

hrs.

min.

9. Birthplace

Frederick County, Md
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

MOTHER FATHER

12. Name

Joseph Grimm

13. Birthplace

Pennsylvania

14. Maiden name

Aranda Laughman

15. Birthplace

Pennsylvania

16. Informant

Alton Grimm

Address

Elmon Bridge R. 41 Md.

17.

(Burial, cremation, or removal. Which?)

Date thereat

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 12, 1948 at 1:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1948

to

Sept 12, 1948

and that I last saw him alive on

Immediate cause of death

Angina Pectoris

DURATION

Due to

Due to

Other conditions

Cholera

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

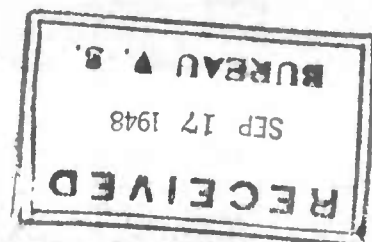
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. A. Jackson M.D.
Elmon Bridge Md
Sept 13, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09289

78

1. PLACE OF DEATH:

County Carroll
 City or town Rural--New Windsor
 (If outside city or town limits, write RURAL and give nearest town)
Life
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Rural -- New Windsor
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Josephine Katherine Hammond

3. (b) Social Security Number

4. Sex 7 5. Color or race @ 6.(a) Single, married, widowed, or divorced f.

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1872 6.(c) If alive, give age years

8. AGE: Years 75 Months 10 Days 22 If less than one day
 hrs. min.

9. Birthplace Frederick Co. Maryland
 (Town, county, and state)
None

10. Usual occupation

11. Industry or business

FATHER 12. Name John F. Hammond
 13. Birthplace Maryland

MOTHER 14. Maiden name Diannah Graham
 15. Birthplace Maryland

18. Informant George Hammond
 Address New Windsor, Md.

17. Burial Burial Date thereof 9-8-48
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Fairview
 Location Covers Corner, Carroll Co. Md.
C. M. Waltz

18. Funeral director Winfield, Md.
 Address

19. Sept 7th 1948 E. M. Farver
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1948, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 1 1948 to September 5 1948
 and that I last saw him alive on August 27 1948

Immediate cause of death Cardiac Failure DURATION

Due to Coronary Insufficiency

Due to

Other conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Merritt E. Robertson M. D. or other

Address New Windsor, Md Date signed Sept. 5, 1948

RECEIVED

SEP 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09290

Reg. Dist. No. 77

1. PLACE OF DEATH:

County Cassall
 City or town Hamptstead (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cassall
 City or town Hamptstead (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Harry W. W. Haul

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S.

6. (b) Name of husband or wife _____

7. Birth date of

deceased (mo., day, yr.)

March 2 - 1873

8. AGE:

Years

Months

Days

If less than one day

7563

hrs.

min.

9. Birthplace

Maryland
 (Town, county, and state)

10. Usual occupation

11. Industry or business

unknown

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Mrs Annie Harris
Hamptstead Md. R.O.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date

(Date rec'd by registrar)

19

48

John S. Hughes Jr.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 5 1948 at 11:00 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1940, to Sept 5 1948

and that I last saw him alive on

Aug 31 1948

Immediate cause of death

Coronary Thrombosis

Due to

Arterio-sclerosis
C-V. Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maurice C. Carter field
Hamptstead Date signed 9/6/48

RECEIVED

SEP 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Mos. 13 Days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore-1-Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 724 N. Stockton Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Melva Mae Henderson

3. (b) Social Security Number

4. Sex female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) September 16, 1932 8. (c) If alive, give age _____ years
 8. AGE: Years 16 Months _____ Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Scholar
 11. Industry or business _____
 12. Name Melvin Fox
 13. Birthplace (unknown)
 14. Maiden name Eleanor Beatrice Henderson
 15. Birthplace Catonsville, Md.

16. Informant Deceased
 Address _____
 17. Burial Date thereof September 27, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Western Star Cem.
 Location _____

18. Funeral director Mrs. Katie R. Williams
 Address 322 N. Schroeder St.
 19. September 24, 1948 Albert R. Williams
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1948, at 3:15 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6, 1948, to September 24, 1948
 and that I last saw her alive on September 24, 1948

Immediate cause of death Pulmonary Tuberculosis
 DURATION April 1948

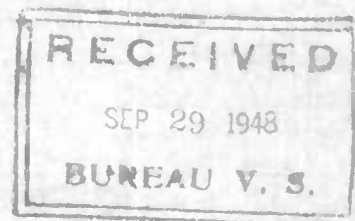
Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Walter Hoffman, M.D. M. D. or other _____
 Address Henryton, Maryland Date signed 9-24-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09292

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 months, 10 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 8 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4 Sherwood Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

EDGAR WILLIAM HOFMEISTER

3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced MARRIED
 6.(b) Name of husband or wife Laura Virginia Garrish
 7. Birth date of deceased (mo., day, yr.) 1/20/98
 6.(c) If alive, give age 48 years
 8. AGE: Years 50 Months 8 Days 7 It less than one day hrs. min.

9. Birthplace Baltimore County
 (Town, county, and state)
 10. Usual occupation A&P Store Manager
 11. Industry or business Grocery store
 12. Name William Hofmeister
 13. Birthplace Baltimore County
 14. Maiden name Lottie Robinson
 15. Birthplace Baltimore County

16. Informant Record, Springfield State Hospital
 Address Sykesville, Maryland

17. Burial Date thereof Sept 29-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Druid Ridge
 Location Pikesville, Md.

18. Funeral director Frank H. Newell
 Address Pikesville, Md.

19. 9/29 48 RW Hedrick
 (Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 19 48 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 17, 19 48, to September 27, 19 48
 and that I last saw him alive on September 27 19 48

Immediate cause of death Bronchopneumonia DURATION 2 days

Due to

Due to

Other conditions Brain tumor, left fronto-parietal lobe (malignant) 19 months
 (Include pregnancy within 8 months of death) (11/4/48-S.)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph H. Marshall M.D.Address Springfield State Hospital Date signed 9/27/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County CarrollCity or town Finksburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CarrollCity or town Finksburg
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Minnie M. Hook

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife William H. Hook7. Birth date of deceased (mo., day, yr.) May 17, 18718. AGE: Years 77 Months 3 Days 24 If less than one day _____ hrs. _____ min.9. Birthplace Balto. Co.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Charles H. Thompson13. Birthplace Baltimore City14. Maiden name Margaret Hergesheimer15. Birthplace Baltimore City16. Informant Charles W. HookAddress Finksburg, Md.17. Burial Date thereof Sept. 13, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Salem CemeteryLocation Upper Falls, Md.18. Funeral director J. F. Elmer, SonsAddress Heisterstown, Md.19. 9/13 19 48 Heisterstown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 19 48 at _____ M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 19 48 to Sept 10 19 48and that I last saw him alive on Sept 9, 1948 19 _____

Immediate cause of death _____

DURATION

Myocarditis - chronic 8 yrs.Due to decompensatingDue to hypertensionOther condition arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

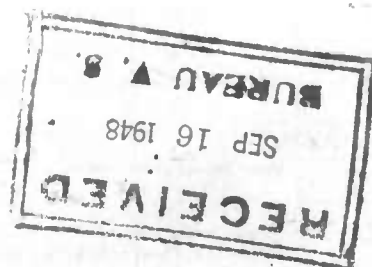
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Heart Injured at work _____23. SIGNATURE Heisterstown M. D. or other _____Address _____ Date signed 9-11-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months 14 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
City or town Baltimore-17-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1327 N. Fremont Street
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

JOSEPH MATTHEW JOHNSON

3. (b) Social Security Number

4. Sex _____ 5. Color or race _____ 6. (a) Single, married, widowed, or divorced _____

Male Col Single

6. (b) Name of husband or wife _____ 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 16, 1913

8. AGE: Year 35 Month 3 Day 25 If less than one day _____ hrs. _____ min.

9. Birthplace Orange, Virginia
(Town, county, and state)

10. Usual occupation Elevator Operator

11. Industry or business _____

12. Name George Johnson

13. Birthplace Orange, Virginia

14. Maiden name Rachel Green

15. Birthplace Frederick, Virginia

16. Informant Deceased

Address _____

17. Burial Date thereof 9/16/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Calvary

Location A. A. County

18. Funeral director Mr. Robert Elliott & daughter

Address 1129 N. Caroline St.

19. Sept. 10 19 48 Albert R. [Signature]
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 19 48 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27 19 47 to Sept. 10 19 48 and that I last saw him alive on September 10 19 48

Immediate cause of death Pulmonary Tuberculosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Newton [Signature] M.D.
M. D. or other _____

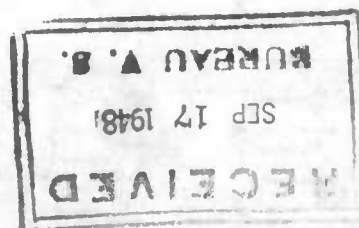
Address Henryton, Maryland Date signed 9/10/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County... Carroll
 City or town... Manchester
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... Entire Life
 Hospital, institution, or street address where death occurred: _____
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED.

(For newborn infants give residence of mother)

State... Md County... Carroll
 City or town... Manchester
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

John Christian Frederick Koch

3. (b) Social Security Number

212-24-3223

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Emma Hoffacker

7. Birth date of

deceased (mo., day, yr.)

Dec 13, 1885

6. (c) If alive, give age

63 years

8. AGE:

Years

Months

Days

If less than one day

62

8

17

hrs.

min.

9. Birthplace

Manchester Md.

(Town, county, and state)

10. Usual occupation

Cigar maker

11. Industry or business

Manuf. Cigars

FATHER

12. Name

Mr. J. Koch

13. Birthplace

Manchester Md.

MOTHER

14. Maiden name

Eliza Hunt

15. Birthplace

Manchester Md.

16. Informant

Elizabeth Barick

Address

Wilmington Md. R. D. #4

17. Burial

(Burial, cremation, or removal) Which?

Date thereof

2-4-48

Cemetery or crematory

Bermet

Location

Manchester Md.

18. Funeral director

Jacob W. R. S. S. S.

Address

Manchester Md.

19. Date rec'd by registrar

Sept. 3 1948

Mr. W. R. S. S. S.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 1, 1948 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death... Cerebral Hemorrhage

DURATION

10 hrs.

Due to... Arterio-sclerotic

Due to... Disease

Other conditions... _____

(Include pregnancy within 3 months of death)

Major findings of operations... _____

Date of op. _____

Autopsy results... _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... _____ Date of... 2

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work? _____

23. SIGNATURE... Joe. E. Bush M.D.

M. D. or other

Address... Hamstead Md. Date signed... 9-1-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09296

7X

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 yrs. 2 months, 14 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 18 yrs. 2 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ---
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. --- 30 E. Ostend St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ---

3.(a) FULL NAME

KERN, Joseph C.

3.(b) Social Security Number

none

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Rose Kern
 7. Birth date of deceased (mo., day, yr.) November 10, 1890
 8. AGE: Years 57 Months 19 Days 28 If less than one day --- hrs. --- min.

9. Birthplace Baltimore City, Md.
 (Town, county, and state)
 10. Usual occupation Printer
 11. Industry or business ---
 12. Name Joseph Kern
 13. Birthplace Maryland
 14. Maiden name Amelia Smith
 15. Birthplace New York State

16. Informant Records of the Springfield St. Hospt.
 Address Sykesville, Maryland
 17. Burial Date thereof 9/11/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Holy Cross Cem.
 Location A. A. Co., Md.
 18. Funeral director WM. J. TICKNER & SONS
 Address Balto., Md.
 19. 9/9/48 ASW Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8, 1948 at 11:20 am
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 1, 1947 to September 8, 1948
 and that I last saw him alive on September 8, 1948
 Immediate cause of death General paralysis of the insane
 Due to Syphilis
 Due to ---
 Other conditions ---
 (Include pregnancy within 8 months of death)

DURATION

20 yrs.unkn.

Major findings of operations ---
 Date of op. ---
 Autopsy results ---
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide --- Date of ---
 Where did injury occur? --- (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) ---
 Means of injury --- Injured at work? ---
 SIGNATURE Martin Gross, M.D.
Martin Gross, M. D. M. D. or other
 Address Sykesville, Maryland Date signed 9/8/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County CarrollCity or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? since 3-30-48

Hospital, institution, or street address where death occurred:

Springfield State HospitalHow long in hospital or institution? since 3-30-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town ---
(If outside city or town limits, write RURAL and give nearest town)Street No. 6600 Windsor Mill Road
(If rural, give LOCATION)2. (a) If veteran, name war ---

3. (a) FULL NAME

KRONE, Arnold Henry

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Wilhelmina KroneBorn 11/21/86 6. (c) If alive, give age --- years7. Birth date of deceased (mo., day, yr.) December 17, 18748. AGE: Years 73 Months 9 Days 1 If less than one day --- hrs. --- min.9. Birthplace Bremen, Germany
(Town, county, and state)10. Usual occupation Retired Civil Engineer11. Industry or business ---12. Name Christian Krone13. Birthplace Bremen, Germany14. Maiden name Caroline -15. Birthplace Germany16. Informant Records of Springfield State HospitalAddress Sykesville, Maryland17. Burial Date thereof Sept 21-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Woodsland CemLocation Adts. Md.18. Funeral director E. W. LammimanAddress 4510 Liberty Rd19. Sept. 18 1948 Registrar W. H. H. H. H.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

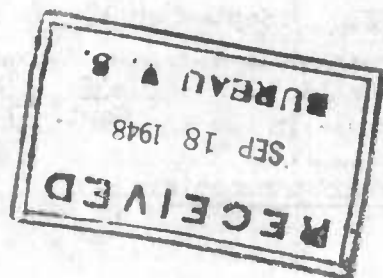
20. DATE OF DEATH September 18 19 48 at 12:10 A.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 13, 19 48 to Sept. 18 19 48
and that I last saw him alive on Sept. 17 19 48Immediate cause of death Bronchopneumonia DURATION 5 daysDue to ---Due to ---Other conditions Arteriosclerosis, Psychosis
with cerebral arteriosclerosis 5 yrs
(Include pregnancy within 3 months of death)Major findings of operations ---Date of op. ---Autopsy results Bronchopneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? --- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---23. SIGNATURE Martin Gross, M. D.
Martin Gross, M. D. M. D. or otherAddress Sykesville, Maryland Date signed 9-18-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09298

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 Yr; 3 Mo. 6 Days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1314 N. Caroline Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

William Leslie Lambirth

3. (b) Social Security Number

219-07-4670

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Mary T. Lambirth
 7. Birth date of deceased (mo., day, yr.) July 21, 1921 8. (c) If alive, give age 21 years
 8. AGE: Years 27 Months 1 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Kinston, N. Carolina
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business _____
 12. Name John. Lambirth Sr.
 13. Birthplace Kinston, N. Carolina
 14. Maiden name Nancy Parker
 15. Birthplace Kinston, N. Carolina

16. Informant Deceased
 Address _____

17. Burial Date thereof September 20, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mount Calvary Cemetery
 Location Anne Arundel Co.
 18. Funeral director Mrs. Little, Groves
 Address 1408 Ashland Ave

19. September 15, 48
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 19 48, at 12:20 P

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 9, 19 47, to September 15, 48
 and that I last saw him alive on September 15, 19 48

Immediate cause of death Pulmonary Tuberculosis
 DURATION March 1943

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Reuben S. Hoffman, M.D.
 M. D. or other _____
 Address Henryton, Maryland Date signed 9-15-48

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. I/we correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of spelling of surname shown MARYLAND STATE DEPARTMENT OF HEALTH

ON:

2411 N. Charles St., Baltimore

FILM No. G 117 OCT 4 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 09299 74

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months, 22 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 5 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County.....
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 529 North Brice Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

A
JOHN HENRY LESTNER

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Catherine Ruettinger Lestner
 7. Birth date of deceased (mo., day, yr.) June 14, 1868
 8. AGE: Years 80 Months 3 Days 14 If less than one day..... hrs. min.

9. Birthplace Baltimore City
 (Town, county, and state)
 10. Usual occupation Blacksmith
 11. Industry or business.....
 12. Name Conrad Lestner
 13. Birthplace Germany
 14. Maiden name Maria Repolet
 15. Birthplace Germany

16. Informant Records, Springfield State Hospital
 Address Sykesville, Maryland
 17. Burial Burial Date thereof 10/2/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Lorraine Cem.
 Location Woodlawn, Md.
 18. Funeral director WM. J. TICKNER & SONS
 Address Balto., Md.

19. 9/30 19 48 A. W. Heffner
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 19 48 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 19 48 to September 28 19 48 and that I last saw him alive on September 28 19 48.

Immediate cause of death Carcinoma of prostate gland DURATION 4 months

Due to.....

Due to.....

Other conditions Senile psychosis, depressed type DURATION 10 years
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE M. Virginia Reyer M.D. M. D. or other
 Address Sykesville, Maryland Date signed 9/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The registrar age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09300

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years, 9 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1317 Myrtle Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

HERBERT ANDREW MASON

3. (b) Social Security Number

218-09-6518

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Separated
 6. (b) Name of husband or wife Margaret Mason
 7. Birth date of deceased (mo., day, yr.) May 5, 1917
 6. (c) If alive, give age 31 years
 8. AGE: Years 31 Months 4 Days 7 It less than one day hrs. min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Waiter
 11. Industry or business
 12. Name Herbert Mason, Sr.
 13. Birthplace Baltimore, Maryland
 14. Maiden name Pearl Smith
 15. Birthplace Baltimore, Maryland

16. Informant Deceased
 Address Baltimore
 17. Buried Date thereof Sept 15, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Inf. Ashmun Cem.
 Location Bald
 18. Funeral director Mrs. Samuel F. Bandy
 Address 578 W. Biddle
 19. Sept. 12, 1948
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12, 1948 at 10:45A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
September 3, 1946 to Sept. 12, 1948
 and that I last saw him alive on September 12, 1948

Immediate cause of death Pulmonary Tuberculosis
 DURATION May 1, 1940

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
 M. D. or other
 Address Henryton, Maryland Date signed 9-12-48

CERTIFICATE OF DEATH

RECEIVED
SEP 14 1943
BUREAU OF S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09301

79

1. PLACE OF DEATH:

County Carroll
 City or town Keymar
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Keymar
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Emma M. Mehring

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Upton F Mehring
 7. Birth date of deceased (mo., day, yr.) December 29, 1867
 8. AGE: Years 80 Months 8 Days 18 If less than one day
 hrs. min.

9. Birthplace Woodstock, Frederick Co. Md.
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business Own home
 12. Name John Smith
 13. Birthplace Frederick County, Md.
 14. Maiden name Mary Jane Giffert
 15. Birthplace Frederick County, Md.

16. Informant Mr. Charles F. Mehring
 Address Keymar, Md.
 17. Burial Date thereof Sept. 10, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Naught's Cemetery
 Location New Midway, Maryland
 18. Funeral director C. O. Fessler & Son
 Address Taneytown, Maryland
 19. Sept. 8 19 48 Paul M. Pawelle
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 19 48, at 1:00 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 19 48, to Sept. 7 19 48, and that I last saw him alive on Sept. 6 19 48.
 Immediate cause of death uremia DURATION 1 mo
 Due to Cardio-vascular-renal disease
 Due to
 Other conditions Hypertension
arteriosclerosis
 (Include pregnancy within 3 months of death)
 Major findings of operations none
 Date of op.
 Autopsy results not done
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, pub'c place (where?)
 Means of injury Injured at work?

23. SIGNATURE M. Frankl. Bickel M. D. or other
 Address Thurmont Md. Date signed 9/18/48

RECEIVED

SEP 10 1948

BUREAU V. S.

EVIDENCE FOR CHANGE MARYLAND STATE DEPARTMENT OF HEALTH
OF DATE OF DEATH SHOWN ON: 2411 N. Charles St., Baltimore
FILM No. G 117 SEP 23 1948 CERTIFICATE OF DEATH

09302

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 3 months, 11 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 yr., 3 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 352 Park Avenue
(If rural, give LOCATION)
2.(a) If veteran, same war. ---

3. (a) FULL NAME

Murdoch, Richard Bruce

3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6. (a) Single, married, or divorced married
6. (b) Name of husband or wife Jemina Walker
6. (c) If alive, give age 79 years
7. Birth date of deceased (mo., day, yr.) August 5, 1870
8. AGE: Years 78 Months 1 Day 9 It less than one day
hrs. --- min. ---

9. Birthplace Frederick, Maryland
(Town, county, and state)
10. Usual occupation Chief clerk
11. Industry or business ---
12. Name Richard Howard Murdoch
13. Birthplace Frederick, Maryland
14. Maternal name Mary Ellen Medeira
15. Birthplace Frederick, Maryland

16. Informant Records of Springfield St. Hospital
Address Sykesville, Maryland
17. Burial Date thereof Sept. 16-48
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory Pleasant Hill Cemetery
Location Monrovia - Maryland
18. Funeral director C. E. Clive & Son
Address Frederick - Maryland
19. Sept. 14, 1948 Officer Keer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

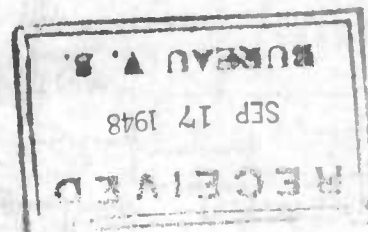
20. DATE OF DEATH August 14, 1948 at 1:40 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947 to September 14, 1948
and that I last saw him alive on September 14, 1948
Immediate cause of death Arteriosclerosis
DURATION unknown
Due to ---
Due to ---
Other conditions Carcinoma of the nose more than 5 mos.
Senile psychosis 4 yrs.
(Include pregnancy within 3 months of death)
Major findings of operations ---
Date of op. ---
Autopsy results Terminal bronchopneumonia
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
Accident, suicide, or homicide --- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? ---
23. SIGNATURE Martin Gross, M.D. M. D. or other
Address Sykesville, Maryland Date signed 8/14/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09303

Reg. Dist. No. 76

1. PLACE OF DEATH:

County CarrollCity or town Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John Granville Myers

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Bertha Koontz Myers7. Birth date of deceased (mo., day, yr.) October 22, 18856. (c) If alive, give age 60 years8. AGE: Years 62 Months 10 Days 17 If less than one day
hrs. min.9. Birthplace Pleasant Valley, Maryland
(Town, county, and state)10. Usual occupation Factory worker11. Industry or business Canning Company12. Name Washington Myers13. Birthplace Maryland14. Maiden name Mary Jane Black15. Birthplace Maryland16. Informant Mrs. Bertha MyersAddress Pleasant Valley, Md.17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept 11, 1948
(month) (day) (year)Cemetery or crematory Pleasant Valley CemeteryLocation Pleasant Valley, Md.18. Funeral director C. O. Fries, SonAddress Janeys town, Md.SEP 9 1948
(Date rec'd by registrar)Clay Fogle
Reg. Seal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8th 19 48, at 12 noon est.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19____, to 19____

and that I last saw him alive on 19____

Immediate cause of death

Suicide - broken neck
from a chain used as
a noose

DURATION

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

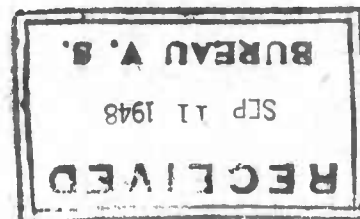
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 9-8-48Where did injury occur? Pleasant Valley, Carroll, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Shot at his homeMeans of injury Iron chain Injured at work? no
used as a noose.23. SIGNATURE W. H. Billingslea, M.D.

Acting Deputy Medical Examiner

Address Weston, Md. Date signed 9-9-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 Months, 25 Days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
 How long in hospital or institution? 4 Months, 25 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Newark
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Elzie Nichols

3. (b) Social Security Number

216-09-6156

4. Sex male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Separated
 8. (b) Name of husband or wife Willsie Nichols
 6. (c) If alive, give age 30 years
 7. Birth date of deceased (mo., day, yr.) September 10, 1909
 8. AGE: Years 38 Months 11 Days 27 It less than one day _____ hrs. _____ min.

9. Birthplace Federalsburg, Maryland
 (Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business _____

MOTHER FATHER
 12. Name Jermiah Nichols
 13. Birthplace Maryland
 14. Maiden name Jennie Cannon
 15. Birthplace Maryland

16. Informant Deceased

Address _____

17. Burial Date thereof Sept 10 - 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Worcester Co

Location Near Snow Hill

18. Funeral director James H. Stewart

Address Collesbury Md

19. September 6, 1948
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1948 at 10:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12, 1948 to September 6, 1948 and that I last saw him alive on September 6, 1948

Immediate cause of death Pulmonary Tuberculosis

DURATION
March
1948.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Nea Ren Hoffman, M.D.
 M. D. or other _____
 Address Henryton, Maryland Date signed 9-6-48

RECEIVED

SEP 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09305

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 Days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Bacontown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Laurel Post Office
 (If rural, give LOCATION) ✓
 2(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

Mamie Perry
 4. Sex Female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife James Perry
 6. (c) If alive, give age 47 years
 7. Birth date of deceased (mo., day, yr.) August 6, 1900

8. AGE: Years 48 Months 1 Days 10 If less than one day
 hrs. min.

9. Birthplace Tarboro, N. Carolina
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Tuner Dickens

13. Birthplace N. Carolina

14. Maiden name Annie Howard

15. Birthplace N. Carolina

16. Informant Mrs. Carrie Knight

Address 1321 W. Lanvale St. Balto.-17-Md.

17. Burial Data thereof Sept 1948-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Tarboro N.C.

Location Elroy O Wilson

18. Funeral director 1000 / Brantley

Address 1000 / Brantley

19. September 16, 1948
 (Date rec'd by registrar)

Deputy Local

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16, 1948, at 10:20 P.M.

21. I CERTIFY that death occurred on the data above stated: that I attended deceased from
September 2, 1948 to September 16, 1948
 and that I last saw her alive on September 16, 1948

Immediate cause of death Pulmonary Tuberculosis
 DURATION December 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Nealea Hoffman, M.D.
 M. D. or other

Address Henryton, Maryland Date signed 9-16-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 18 1948
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09306

74

1. PLACE OF DEATH:

County.....CarrollCity or town.....Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution?.....Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....City or town.....Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No.....1600 Latrobe Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

CLIMITHON HAWTHORNE POWELL

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

Separated6. (b) Name of husband or wife.....Elizabeth Powell

7. Birth date of deceased (mo., day, yr.)

February 28, 1909

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

3972

hrs.

min.

8. Birthplace.....Hickory Grove, S. Carolina
(Town, county, and state)10. Usual occupation.....Laborer

11. Industry or business

MOTHER FATHER

12. Name.....Reuben Powe ll13. Birthplace.....S. Carolina14. Maiden name.....Hannah Good15. Birthplace.....S. Carolina18. Informant.....Sister- Mrs. Olivia ColesAddress.....1600 Latrobe Street, Baltimore-2-Md.

17. (Burial, cremation, or removal. Which?)

Date thereof.....10/2/48
(month) (day) (year)

Cemetery or crematory.....

Location.....Blackburg S.C.18. Funeral director.....Mrs. Powell, HersleyAddress.....5-78 W. Biddle Street19. Sept. 30
(Date rec'd by registrar)Deputy Local

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....September 30 1948 at 7:00 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 30 1948 to September 30 1948and that I last saw him alive on September 30 1948

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

June1947

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....Reuben Hoffman, M.D.

M. D. or other

Address.....Henryton, Maryland Date signed.....9/30/48

RECEIVED

OCT 4 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09307

Reg. Dist. No.

76

1. PLACE OF DEATH

County Carroll Co
City or town Westminster Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? About 2 years

Hospital, institution, or street address where death occurred:

81 Penna. Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Westminster
(If outside city or town limits, write RURAL and give nearest town)Street No. 81 Penna. Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Lillian Ruby Reed

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Charles Reed6. (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.)

Sept. 14, 1877

8. AGE:

77 Years 0 Months 7 Days hrs. min.

9. Birthplace

Leesville Carroll Co. Md
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

J. Wesley Ruby

12. Name

Carroll Co. Md

13. Birthplace

Sarah S. Harris

14. Maiden name

Carroll Co. Md

15. Birthplace

Mrs. Charles Reed

16. Informant

81 Penna. Ave. Westminster Md

Address

Burial Date thereof Sept. 23, 48

(Burial, cremation, or removal, which?)

Cemetery or crematory St. John's Lutheran CemeteryLocation Rural near Westminster Md

18. Funeral director

J. E. Rogers, Jr.

Address

Westminster Md

19. (Date rec'd by registrar)

9/21 48 Registrar W. J. Reed

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21st 1948 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 - 1940 to Sept 21 - 1948and that I last saw him alive on Sept 20 - 1948Immediate cause of death acute myocardial infarction DURATION todayDue to Diabetes Mellitus 20 yrsDue to arterio sclerosis 3 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

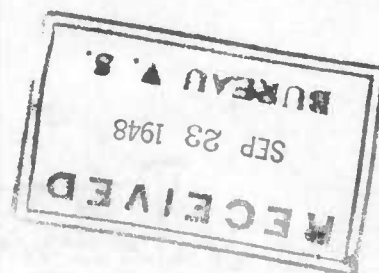
Means of injury Injured at work?

23. SIGNATURE Chas R. Fort, M.D. M. D. or otherAddress Westminster Md Date signed 9-21-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll
 City or town Rural Westminster
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

County Home
How long in hospital or institution? 2 months at County

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Carroll

City or town Rural Westminster
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Concord Home
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Flossie Rimmerman

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife.....

—

7. Birth date of

deceased (mo., day, yr.)

About 1863

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

About 85

.....hrs.min.

9. Birthplace Carroll County home, Md.
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER

12. Name

not known

13. Birthplace

" "

MOTHER

14. Maiden name

not known

15. Birthplace

" "16. Informant George W. Bankert StewardAddress Box 167 Westminster Md.17. Burial
 (Burial, cremation, or removal, Which?)Date thereof Sept. 18, 1948
 (month) (day) (year)Cemetery or crematory Carroll County home CemeteryLocation Westminster, Md.18. Funeral director NB Bankard & SonAddress Westminster, Md.

19. 9/18/48
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19..... to 9-15- 1948
 and that I last saw her alive on 9-16-48 19.....

Immediate cause of death

Pulmonary edema

DURATION

10 d

Due to high systolic pressure
age

6 mos.

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NO Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? NO
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE Dr. C. H. H. H. M. D. or.....

Address Westminster Date signed 9/18/48

RECEIVED
SEP 20 1948
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09309

Reg. Dist. No.

80

932

1. PLACE OF DEATH:

County Carroll
City or town Rural New Windsor #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural New Windsor #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Jesse Robertson

3. (b) Social Security Number

701

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Lela Baker
7. Birth date of deceased (mo., day, yr.) Nov. 11 - 1880
6. (c) If alive, give age 36 years
8. AGE: Years 67 Months 9 Days 24 If less than one day
hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1948 at 10 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 40 Sept. 5 1948
and that I last saw him alive on Sept. 4 1948

Immediate cause of death Arteriosclerosis & hypertension
Chronic Myocarditis

DURATION
years
years

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

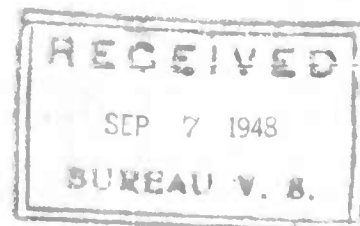
23. SIGNATURE James T. March M.D.
Address Washington Md M. D. or other
Date signed 9-6-48

9. Birthplace Carroll
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
12. Name John Robertson
13. Birthplace Carroll Co. Md.
14. Maiden name Rebecca Arnold
15. Birthplace Carroll Co. Md.
16. Informant Mrs Lela Robertson
Address New Windsor P.D. 1. Md.
17. Burial Date thereof Sept 8 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Pipe Lake Methodist Cem.
Location New Windsor P.D. 1. Md.
18. Funeral director N. Bank and son
Address Westminster, Md.
19. Sept 6 48 E. S. Bruch
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Handwritten text, possibly a signature or date, is visible at the bottom of the page.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09310

Reg. Dat. No. 82

1. PLACE OF DEATH: Carroll
County.....
City or town..... Mt. Airy,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland..... County..... Carroll
City or town..... Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME SARAH ANN RUDY

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Edgar C. Rudy
..... 6. (c) If alive, give age 75 years
7. Birth date of deceased (mo., day, yr.) July 19, 1892
8. AGE: Years 56 Months 2 Days 2 If less than one day
..... hrs. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)
Housewife

10. Usual occupation.....

11. Industry or business.....

12. Name..... John W. Williams

13. Birthplace..... Maryland

14. Maiden name..... Ruth Ann Merryman

15. Birthplace..... Maryland

16. Informant..... Mr. Edgar C. Rudy

Address..... Mt. Airy, Md.

17. Burial Date thereof 9-24-48
(Burial, cremation or removal, which?) (month) (day) (year)
Reformed
Cemetery or crematory.....
Location..... Middletown, Frederick Co. Md.

18. Funeral director..... C. M. Waltz

Address..... Winfield, Md.

9/24 48 Thos D Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 21, 1948, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 1948 to Sept 21, 1948
and that I last saw her alive on Sept 21, 1948

Immediate cause of death..... Duration

Carcinoma of left breast with general metastasis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... C M Van Poale
M D. Cochrane
Address..... Mt Airy Date signed 9/33



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

09311

76

1. PLACE OF DEATH:

County..... Carroll
 City or town..... Finksburg RD 1.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 28 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Carroll
 City or town..... Finksburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Route 1
 (If rural, give LOCATION)
 2.(a) If veteran, name was..... none

3. (a) FULL NAME

Felix A. Ruff

3. (b) Social Security Number

none

4. Sex..... male
 5. Color or race..... white
 6. (a) Single, married, widowed, or divorced..... widowed

6. (b) Name of husband or wife..... Emma Ruff
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... October 29, 1865
 8. AGE: Years..... 82 Months..... 10 Days..... 16
 If less than one day..... hrs. min.

9. Birthplace..... Carroll County, Md.
 (Town, county, and state)

10. Usual occupation..... farm labor

11. Industry or business.....

12. Name..... Godfrey Ruff

13. Birthplace..... Maryland

14. Maiden name..... Achsah Hall

15. Birthplace..... Maryland

16. Informant..... Mrs. Agnes Johnson

Address..... Baltimore, Md.

17. burial Date thereof..... 9/16/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Sandy Mount Cemetery

Location..... Sandy Mount Md.

18. Funeral director..... J. Francis Reese

Address..... Westminster, Md.

19. 9/16/48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 14 1948 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 8, 1948 to September 11, 1948
 and that I last saw him alive on September 11, 1948

Immediate cause of death..... Coronary Occlusion DURATION..... 4 days

Due to..... Arteriosclerosis, General & myocardial General

Due to..... Degeneration General

Other conditions..... Prostatic Hypertrophy

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

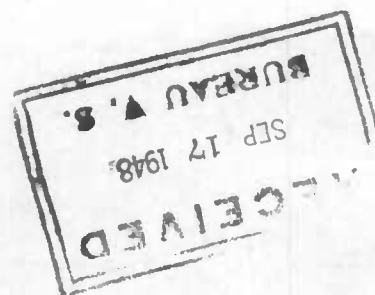
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... William J. Specker M. D. or other

Address..... Westminster, Md. Date signed..... 9/14/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

09312

107

1. PLACE OF DEATH:

County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years, 7 months, 22 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 15 years, 7 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
City or town Fearns
(If outside city or town limits, write RURAL and give nearest town)
Street No. unknown
(If rural, give LOCATION)
2(a) If veteran, name war ✓

3. (a) FULL NAME

Camelia Megey SAVAGE

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
B. (b) Name of husband or wife unknown
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) February 12, 1866
8. AGE: Years 82 Months 6 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Sand Springs, Maryland
(Town, county, and state)
10. Usual occupation housewife
11. Industry or business _____
12. Name Gabriel Friend
13. Birthplace Maryland
14. Maiden name Savage
15. Birthplace Maryland

16. Informant Hospital records
Address Springfield State Hospital
17. Burial Date thereof Sept 4 1948
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory Springfield Hosp. Cem.
Sykesville Md.
Location _____
18. Funeral director Harry Yeer
Address Sykesville Md.
19. Sept 4 48 Harry Yeer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 19 48 at 6 p. m.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
January 2, 19 42, to August 31, 19 48.
and that I last saw her alive on August 31, 19 48.
Immediate cause of death broncho-pneumonia DURATION 2 days
Due to generalized arteriosclerosis 15 years
Due to _____
Other conditions Manic depressive psychosis 30 years
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE Irene Hetchman, M.D.
Springfield State Hosp. M. D. or other 9-1-48
Address _____ Date signed _____

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09313

83a

Reg. Dist. No. 74

1. PLACE OF DEATH:

County..... Carroll
 City or town..... Lynchville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 yrs 3 mo 12 da
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution?..... 3 yrs 3 mo 12 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Ind County..... Bello
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street..... 3148 Woodbine Ave
 (If rural, give LOCATION)..... (Parkville)
 2. (a) If veteran, name war..... ☒

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex..... M 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... Married
 6. (b) Name of husband or wife..... Joseph D. Schneider
 7. Birth date of deceased (mo., day, yr.)..... Oct 10th 1870 6. (c) If alive, give age..... 5 years
 8. AGE: Years..... 77 Months..... 11 Days..... 17 It less than one day..... hrs. min.

9. Birthplace..... Uella Ind.
(Town, county, and state)10. Usual occupation..... Dependent11. Industry or business..... George Metzger12. Name..... George Metzger13. Birthplace..... Germany14. Maiden name..... Margaret Bowers15. Birthplace..... Germany16. Information..... Mrs Margaret KirbyAddress..... 3148 Woodbine Ave17. Burial..... Burial Date thereof..... Sept 30 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... ParkwoodLocation..... Taylor Ave18. Funeral director..... L. HEEMANN & SONAddress..... 6067 HARFORD Rd.19. 9-29 19 48 A. W. Seibel

(Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 27th 1948 at 10-53 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 13 1943 to Sept 27 1948and that I last saw her alive on Sept 27 1948Immediate cause of death..... Cerebral Hemorrhage DURATION..... 2 hrsDue to..... Arterio Sclerosis 10 yrs

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... W. J. Gaston M.D.Address..... Lynchville Ind. Date signed..... 9/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

09314

76

1. PLACE OF DEATH:

County Lebanon
 City or town Rt. 140 - Route 140
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: —How long in hospital or institution? —

3. (a) FULL NAME

Donald M. Shulley

3. (b) Social Security Number

184-09-3810

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.)

March 4, 1920

6. (c) If alive, give age..... years

8. AGE:

28 Years6 Months8 Days

It less than one day

..... hrs. min.

9. Birthplace

Ortanna, Adams Co. Penna.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

Louis Shulley

13. Birthplace

Adams Co. Penna.

14. Maiden name

Bertha Louchbaum

15. Birthplace

Adams Co. Penna

16. Informant

Personal papers

Address

Removal

17.

(Burial, cremation, or removal. Which?)

Date thereof

Sept. 12, 1948

(month) (day) (year)

Cemetery or crematory

Gettysburg, Penna.

Location

J. Francis Reese

18. Funeral director

Westminster, Maryland

Address

19.

(Date rec'd by registrar)

19.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Pa.

County

Adams

City or town

Ortanna

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Main St.

(If rural, give LOCATION)

2. (a) If veteran, name was

World War 11

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 1219482:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h..... alive on..... 19.....

Immediate cause of death

Fracture Cervical Vertebrae

DURATION

Due to

Automobile Accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

9-12-48

Where did injury occur?

Route 140 - Westminister

(City or town)

Adams Co. Md

(County)

140

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Automobile turned over

Injured at work?

23. SIGNATURE

James T. Howard, Deputy Medical

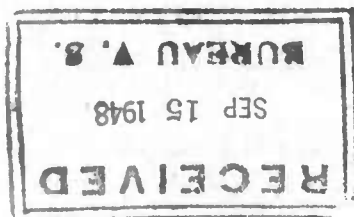
M. D. or other

Address

Westminister Md

Date signed

9/12/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months 18 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland
Baltimore County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 656 George Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3.(a) FULL NAME

DOROTHY MARIE SMITH

3.(b) Social Security Number

4. Sex Female 5. Color or race COL. 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife
 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 15, 1926

8. AGE: Years 21 Months 9 Days 20 (hrs. min.)
Baltimore, Maryland

9. Birthplace (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name William Smith

13. Birthplace Ellicott City, Maryland

14. Maiden name Careda Jones

15. Birthplace Ellicott City, Maryland

16. Informant Deceased

Address

17. Burial Date thereof 9/16/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory mt cathy cent

Location A.A. counted up rd

18. Funeral director A. Heistad

Address 918 Dm 1 Hkly. in

19. September 4 19 48

(Date rec'd by registrar)

Alfred R. Swann
 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 19 48 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 19 48 to September 4 19 48
 and that I last saw h. or alive on September 4 19 48

Immediate cause of death Pulmonary Tuberculosis
 DURATION November 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE Nathan Hoffman, M.D.

Henryton, Maryland M. D. or other

Address Date signed 9/4/48

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SEP 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 81.

1. PLACE OF DEATH:

County CarrollCity or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Harry E Stitely

3. (b) Social Security Number

218-07-2581

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Edna Irene Stitely

7. Birth date of deceased (mo., day, yr.)

March 15-1870

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

78519

hrs.

min.

9. Birthplace

Grederick County
(Town, county, and state)

10. Usual occupation

carpenter

11. Industry or business

contractor

MOTHER

12. Name

Joel Stitely

13. Birthplace

Maryland

14. Maiden name

Ella Stitely

15. Birthplace

Maryland

16. Informant

Mrs. J. N. Zagle

Address

Baltimore, Md

17.

(Burial, cremation, or removal, Which?)

BurialDate thereof Sept 5-1948

Cemetery or crematory

mt Union Cemetery

Location

Union Bridge

18. Funeral director

D. O. Hartzler & Sons

Address

Union Bridge & New Windsor, Md

19.

(Date rec'd by registrar)

19 48W. Eichman

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 319 48

at

8:50^{am}

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 119 48

to

Sept 319 48

and that I last saw him alive on

Sept 219 48

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to

Due to

331

Other conditions

83a

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Zagle

M. D. or other

Address

Union Bridge

Date signed

9-3-48

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APR 9 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

09316

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year 4 months 24 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 51 A Douglas Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

LUCILLE MARY LEE STREETER

3. (b) Social Security Number

218-20-8819

4. Sex Female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 18, 1928
 8. AGE: Years 20 Months 6 Days 3 if less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Factory Worker
 11. Industry or business _____

FATHER
 12. Name Charles Streeter
 13. Birthplace Maryland
 MOTHER
 14. Maiden name Jane Ellis
 15. Birthplace Maryland

16. Informant Deceased
 Address _____

17. buried Date thereof 9-23-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cemetery
 Location Taylor's Island Md.

18. Funeral director Lewis A. Henry
 Address Centerville Md.

19. Sept. 21 1948
 (Date rec'd by registrar) Deputy Registrar Alfred P. [unclear] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1948 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1947 to Sept. 21 1948
 and that I last saw her alive on September 21 1948

Immediate cause of death Pulmonary Tuberculosis
 DURATION February 1947

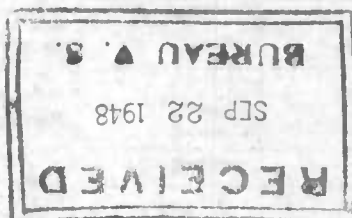
Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accidental, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Robert Hoffman, M.D. M. D. or other _____
 Address Henryton, Maryland Date signed 9/27/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County CarrollCity or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore-13-
(If outside city or town limits, write RURAL and give nearest town)Street No. 1051 Harford Avenue
(If rural, give LOCATION)2. (a) If veteran, name war ☒

3. (a) FULL NAME

CLARENCE STROUD

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>Col.</u>	<u>Separated</u>

6. (b) Name of husband or wife Thelma Stroud6. (c) If alive, give age 31 years7. Birth date of deceased (mo., day, yr.) December 3, 1919

8. AGE:	Year	Months	Days	If less than one day
	<u>28</u>	<u>8</u>	<u>29</u> hr. min.

9. Birthplace Reedville, S. Carolina
(Town, county, and state)10. Usual occupation Contractor

11. Industry or business

12. Name Clarence Stroud13. Birthplace Unknown14. Maiden name Barbara Graves15. Birthplace Unknown16. Informant Deceased

Address

17. Burial Date thereof 9-4-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. CalvaryLocation P. A. Co.18. Funeral director Payner SandersAddress 1412 E. Preston St.19. Sept. 1 19 48 Albert J. Smith
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 19 48 at 1:45 A.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 16 19 48 to September 1 19 48and that I last saw him alive on September 1 19 48Immediate cause of death Pulmonary TuberculosisDURATION January 1943

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Neuben Hoffman, M.D. M. D. or otherAddress Henryton, Maryland Date signed 9/1/48

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

RECEIVED

SEP 3 1948

BUREAU V. S.